To be approved by the Subcommittee

MINUTES
MENTAL HEALTH SUBCOMMITTEE
9:00 A.M.
FRIDAY
JULY 13, 2007
SUPREME COURT BASEMENT CONFERENCE ROOM
BOISE, IDAHO

The meeting was called to order by Cochairman Senator Joe Stegner at 9:05 a.m. Other members present included Cochairman Representative Sharon Block, Senator Tim Corder, Senator Patti Anne Lodge, Representative Fred Wood and Representative Margaret Henbest. Legislative Services Office staff present were Eric Milstead, Amy Castro and Toni Hobbs.

Others present were Magistrate Judge Bradly Ford, Canyon County; Larry Callicutt, Juvenile Corrections; Dr. Mary Perrien, Kevin Kempf and Scott Johnson, Department of Correction; Kathleen Allyn, Todd Hurt and Bill Talbott, Department of Health and Welfare/Behavioral Health; Holly Koole, Ada County Prosecutors Office; Corey Surber, Saint Alphonsus; Gary Payne and Candice Crow, Idaho Psychological Association; Bob Seehusen, Idaho Hospital Association; Representative Nicole LeFavour, District 19; Tony Poinelli, Association of Counties; Woody Richards, Intermountain Hospital; Molly Steckle, Idaho Medical Association/Idaho Psychological Association; Jonathan Stanley, Treatment Advocacy Center; Tracey Sessions, Department of Health and Welfare Region 7; Doug Call and Carine Call, National Alliance on Mental Illness; Steve Millard, Idaho Hospital Association; Linda Hatzenbuehler, Bannock County Designated Examiner; Ralph Blount and Steve Bywater, Attorney General's Office; Susan Broene, Idaho State School and Hospital; Amy Holly Priest and Lynn Darrington, Business Psychology Association; John Miller, Associated Press; J.R. Van Tassel and Teresa Wolf, Nez Perce County; Ted McDonald, Boise State University and Kathie Garrett.

Senator Stegner began with some background information regarding the formation of this subcommittee. He stated that the preliminary emphasis of this subcommittee has been to review the commitment laws of the state of Idaho. In his opinion some progress has been made in advancing mental health services in the state and now it is time to be more specific in addressing statutes that deal with mental health issues. He said there has been some significant publicity in Idaho commitment laws and whether they are sufficient to deal with some of the emerging problems across the state. He said he was referring to some of the more tragic events involving individuals with mental illness conditions committing violent crimes even though they have been

identified as having mental illness issues and have been observed by the social system in Idaho.

Senator Stegner said it was his hope that this subcommittee would also be able to review the capacity of the state hospital system. In his opinion the state hospital capacity seems to be deficient, especially in the Treasure Valley, and that needs to be looked at for all areas of the state in order to eliminate the waiting lists that exist for involuntary commitments that must go into those specific facilities. He would also like to expand the capability of the state hospitals to include voluntary commitments and some substance abuse assistance.

Todd Hurt, Field Operations Manager for Region 3 Behavioral Health/ Department of Health and Welfare spoke to the subcommittee on the volume of commitment work going on currently. He also discussed some general trends seen in Region 3 which includes Adams, Washington, Gem, Owyhee, Canyon and Payette counties.

Mr. Hurt commented that in 2000-2001, the number of mental holds identified in the region was about 30 per month. Today that average is about 80 per month. Region 4 averages about 100 per month and he noted that care facilities in the valley are used to house people from both Region 3 and Region 4. He stated that there are approximately 500 holds every three months that are managed by two crisis teams and law enforcement.

Mr. Hurt explained that both Region 3 and Region 4 work with local hospitals (Intermountain, St. Als and West Valley) that have inpatient psychiatric care facilities to negotiate bed space for these holds.

He stated that emergency rooms get jammed up in local hospitals to deal with these holds and if there is no bed capacity the person is placed with law enforcement until beds are found. He said they have had to send people to Twin Falls for beds and that sometimes people are committed medically and stabilized until psychiatric beds become available.

Magistrate Judge Bradly Ford from Canyon County was introduced to discuss Idaho Commitment Laws. **Judge Ford** explained that he has been a magistrate for 10 years in Canyon County and practiced law there for 18 years.

Judge Ford stated that everyone in the judiciary deals on a routine basis with people that are suffering from mental illness. He said this is a great concern because if it is not dealt with in the commitment process, it is seen in the criminal process. He said development of the mental health court as well as including mental health treatment with the processing of criminal cases, is helping. The mental health courts have also empowered judges and district judges to order mental health evaluations and treatment as part of the sentencing process. He said he wanted to emphasize that, as a lifelong resident of Canyon County, he has witnessed an extraordinary change in the community. He said the growth in the valley, especially in the last ten years, is impacting mental health.

Judge Ford explained that Canyon County has eight sitting magistrates and outside judges are brought in if necessary. When a commitment hearing needs to be held, whoever (judge) is scheduled to be in court, must take care of it. He said this is a very unique area and sometimes it is not as complicated as other types of hearings and noted that except for the actual commitment hearing, all of the other requirements and forms and other matters are handled ex parte or out of courtroom. **Judge Ford** said that he handles from one to five commitment hearings per week. He noted that considering that all eight judges handle the same amount of hearings, that is quite a lot of commitment hearings.

Judge Ford moved on to provide a general summary of the legal procedures involved in the commitment process under Idaho Commitment Laws, Chapter 3, Title 66, Idaho Code.

Judge Ford explained that the commitment provisions of the Idaho Code are used when an interested person is concerned that someone suffering from mental illness is in such a state of dysfunction that the mentally ill person should be evaluated and considered for possible commitment. The four most common sources for the initiation of commitment proceedings are law enforcement, emergency room personnel, mental health facilities where a voluntary patient seeks to terminate voluntary treatment and leave the facility, and local jails.

Judge Ford stated that the definitions set forth in section 66-317, Idaho Code, are crucial to the commitment process. Words in this section that are commonly used by the court include:

- Designated Examiner (DE)
- Facility
- Lacks capacity to make informed decisions about treatment
- Mentally ill
- Gravely disabled
- Likely to injure himself or others

These terms are used and applied to the facts of the cases.

Judge Ford went on to discuss other statutes that are important to his work on commitment cases. These code sections include 66-318, 66-319, 66-320, 66-322, 66-326, 66-327, 66-329, 66-330, 66-331, 66-333, 66-334, 66-337, 66-338, 66-339, 66-339B, 66-339C, 66-342, 66-343, 66-334, 66-345, 66-346 and 66-347.

Judge Ford noted an inconsistency in section 66-320, Idaho Code, dealing with the right of a voluntary patient to leave a facility versus the right of the facility director to detain a patient for purposes of examination by a DE. This section says a patient can be held for three days not including weekends/holidays, but section 66-326, Idaho Code, only allows 24 hours for the prosecuting attorneys to handle these issues.

Judge Ford stated that section 66-322, Idaho Code, includes the procedure to initiate guardianship proceedings for a mentally ill person who is incapacitated. He said this is not used very often and he sees it as a valuable tool that would allow family members of a mentally ill

person to be able to make decisions for them. He noted that the Community Board of Guardians has used this in some cases.

According to **Judge Ford**, section 66-326, Idaho Code, is one of two provisions most routinely dealt with. This section is the basis for initiating many voluntary commitments and authorizes persons to intervene with someone who needs treatment for mental illness. It allows a person to be detained for evaluation. He explained that once a person is held under detention, evidence must be submitted to the court within 24 hours. If the court determines it is appropriate, an order is issued for a temporary hold and a designated examination. He said that by the time a case reaches this stage a designated examination has usually been done and submitted to the court with an application for continued temporary detention so another designated examination can occur. The designated examiner who does the second exam is supposed to submit to the court within 24 hours their evaluation of the patient. If the evaluation shows that the person meets the criteria for commitment, the prosecuting attorney will file an application for commitment within another 24 hours. **Judge Ford** said that under these provisions, commitment is a three day process or less. He said generally they take place in less than three days. The commitment hearing is supposed to be held in less than five days.

Section 66-329, Idaho Code, outlines the procedures, burden of proof, and required findings for an involuntary commitment. **Judge Ford** said this statute and its proceedings are most commonly used by the court. He noted that, during this time period, many cases are dismissed because while the person is receiving treatment the symptoms go away. The judge stated that this reflects the idea of the revolving door in the Model Law because many people are continually picked up, treated and released, but are picked up again and again because they do not continue their treatment.

He said as a magistrate judge he sees a connection between substance abuse and mental illness. He said that substance abuse can lead to symptoms of mental illness and that the mentally ill tend to self-medicate, which leads to substance abuse, which leads to trouble with the law, arrest and entrance into the law enforcement system. In his opinion, the mental health courts are a good idea because they deal with a mentally ill person who has been convicted of criminal activity. These courts deal with the illness and get the person on a proper drug treatment plan. This can help them get away from criminal activity.

Judge Ford said there is a need to define who is responsible to transport these people to the court. He said many times people being taken to court for a commitment hearing are transported by law enforcement and enter the courtroom in shackles and/or handcuffs. This also takes up law enforcement resources to transport these people to court. Many cities do not want to transport individuals from one facility to another so it becomes the responsibility of the county sheriff. He noted that Canyon County has just agreed to provide transportation until there is a clear determination of whose responsibility that really is.

Another inconsistency, according to **Judge Ford** is that the fact that the statute says the hearing shall

be informal but also says a record shall be made and the rules of evidence shall apply. In reality this is not very informal, it is a court hearing.

He stated that most people for whom hearings are held are committed (90%). He added that often the newest prosecutor in the office is assigned to these hearings so they are not that experienced.

Judge Ford stated that one area of the current law they struggle with is that sometimes there are four certificates from different designated examiners but only one designated examiner comes to court. If the public defenders want to challenge the matter, they object that these other reports and certificates are hearsay documents and should not be admitted. He said there have been different rulings by different judges as to how this is handled. Canyon County uses the exception that says if hearsay is otherwise reliable and the person offering it gives advance notice to the opposing side of their intent to use it, the court can admit it.

Judge Ford continued that after the evidence has been heard, the court is required to make findings of fact and conclusions of law. The standard they are required to use is to prove by clear and convincing evidence (this is higher than most civil cases) that the patient is mentally ill and because of that condition is likely to injure himself or others or is gravely disabled due to the mental illness. If those conditions are found to exist, the court will order the patient committed to the custody of the department director for an indeterminate period not to exceed one year. The department director shall determine within 24 hours the least restrictive available facility consistent with the patient's needs.

Judge Ford pointed out that he tries to make the process as humanizing as possible and tries to talk to the patient and let them know that everyone wants them to get better. He said that seems to relax the patient and reassures them that everything is going to be okay.

Section 66-338, Idaho Code, deals with conditional release after involuntary commitment. This involves requirements a patient must comply with in order to be released. If treatment or the conditions are not met, the patient will be rehospitalized. **Judge Ford** noted that if someone is conditionally released and it is determined they need to be rehospitalized, they must go through an almost identical commitment process as the initial hearing.

Section 66-339A, Idaho Code, sets forth the procedures and basis for outpatient commitment. **Judge Ford** said that he has never seen this used in his 10 years on the bench.

He stated that the Model Law includes new criteria for commitment for chronic mental health disorders. This is helpful for family members who become frustrated because in order to help a family member currently, they have to wait until that person is a danger to himself or others.
Sections 66-344, 66-446, and 66-447, Idaho Code deal with reaffirmation of patient rights, "humane treatment," restricted use of restraints and seclusion, right to communicate and visit, and habeas corpus.

Judge Ford emphasized again the importance for the judge to have empathy no matter who they are dealing with. Family members have a lot of pain in dealing with those who have mental illness.

He said that the U.S. Supreme Court has set due process standards that must be adhered to in the mental health process and that is reflected in Idaho statute. He added that the mental health courts are an attempt to deal with the mentally ill in the criminal system.

Judge Ford voiced his concern with the general lack of resources, not only for Health and Welfare but with facilities and the court system and said somehow this needs to be addressed.

In response to a comment from **Representative Henbest, Judge Ford** agreed that there is not a lot of dysfunction within Idaho law. He said the procedures go quickly and patients' rights are protected. As he stated earlier, much is handled ex parte up to the hearing itself. He said these cases for judges are not extremely difficult. He admitted they handle a lot of cases but there are enough magistrates to take care of it at this time. He noted that some outlying counties face difficulties. If the judge is not available that day, they have to track a judge down and fax documents and so on. He also said there are issues regarding transporting mentally ill persons to appropriate facilities from some of the more rural counties.

Representative Henbest said that transport is an issue that the Legislature has heard a lot about. Especially transporting a nonviolent, mentally ill person in the back of a squad car and so on. She asked how it came about that law enforcement is the most common form of transport. **Judge Ford** stated that law enforcement is designated by statute as one entity that can handle the temporary detention and they are probably the most trained in dealing with someone who may be a physically resistant person. In his opinion hospital personnel are not trained to do that.

Representative Block commented regarding family members concerned with the fact that they can not get help before a person becomes a danger to themselves or others. In her opinion as a kindergarten teacher, she thinks signs can be identified early on before it gets too far along. **Judge Ford** agreed and stated that children's mental health issues are extremely important. He said that intervention at an early stage is important in order to provide better mental health care but he noted that there needs to be more vigilance in regard to families that are neglecting children or abusing them. He said he has always been very concerned with children who are taking care of themselves while their parents are abusing drugs and what a profound effect this has on the children.

Senator Stegner said it has been difficult to bring attention to the issue of mental health and he has tried for some time to get the press to attend some of these meetings.

Judge Ford commented that he deals with people in every aspect of the law. He said that he has set a zero tolerance policy. If he is hearing a divorce/custody case and both parents are addicted to meth, he tells them they will take drug tests and if they slip off, they will lose the right to visit the child.

Senator Stegner said from **Judge Ford's** comments he is assuming that the system in Idaho is

functioning and not broken. **Judge Ford** said he has compared Idaho's law to the Model Law and thinks there are a lot of consistencies. In his opinion it just needs more fine tuning.

Senator Stegner said in his opinion there are issues dealing with criminalization, the revolving door problem, and lack of resources. He noted that there are things that can be improved that can assist the judiciary, patients and families and a way to realize a cost-effectiveness in all of this. **Judge Ford** agreed.

In response to a question from **Representative LeFavour** regarding outpatient commitment and transportation issues, **Judge Ford** explained that family members can file a petition for commitment or outpatient commitment. He said a problem with this in many cases is these people are very poor and do not have the resources to hire an attorney to file a petition. He said if somehow resources could be made available for these families, that would be helpful. Regarding the transportation question, **Judge Ford** said in some areas case workers try to transport patients to where they need to go to get services and care.

Senator Corder asked about the relationship between the Veterans Administration and mental health commitment. **Judge Ford** said he is not aware of the disposition system but if resources are available a qualified person would be placed in those facilities.

Senator Corder said he would like to see information about the percentage and disposition of veterans. **Tracey Sessions**, Region 7, Department of Health and Welfare said that for veterans in the Salmon/Challis area, there is a tele-psychiatry program available on a regular basis. She said they have the same capability in Twin Falls. She noted that this is a growing concern and need and if the option of using the Veterans Administration exists, a person is referred there as soon as possible.

Senator Corder asked whether the revolving door problem is minimized if someone is referred to a veterans facility. **Judge Ford** said that he does not have statistics as to how successful those programs are. In his opinion, it would be helpful if there was a way to encourage people to access treatment before it becomes a crisis situation.

In response to a question from **Senator Stegner, Judge Ford** said he has never had a writ of habeas corpus filed.

Jonathan Stanley, Assistant Director, Treatment Advocacy Center was introduced to give an overview of the Model Commitment Law. He stated that the Treatment Advocacy Center's prime focus is commitment reform and that he was very excited to talk to the Task Force about this. **Mr. Stanley** noted that in looking at Idaho law he did not see that many difference between the Model Law and Idaho from a legal standpoint.

He began with some background on mental illness and mental health care. **Mr. Stanley** said that in 1965 in the United States there were about 500,000 patients institutionalized for mental health care.

Today there are about 50,000 to 60,000. In the 1960s a movement began to take people out of institutions and put them back in the communities. Today 13 out of 14 of those people hospitalized in the 60s are living in society.

Mr. Stanley said that with this new wave of deinstitutionalization, a new breed of commitment laws was implemented. These new laws, instead of just relying on someone saying that someone else was sick and needed treatment, focused on danger. By the 1970s virtually every state had changed its laws to trigger commitment only on the grounds of danger; normally imminent or immediate danger.

This split mental illness into three groups. The first group were those capable of making rational decisions concerning their treatment. The second group were those demonstrably dangerous and, in this case, law enforcement, mental health professionals and family members could step in and get help. The third group were people rendered irrational by their illness but not demonstrably dangerous. For these people nothing could be done.

Mr. Stanley went on to say that hundreds of thousands of people were taken out of institutions and placed into communities. Laws were set up and programs or lack of programs made it very difficult for people to get treatment when they were in crisis. **Mr. Stanley** said that as a result of this almost 200,000 of today's homeless population have a severe mental illness and sixteen percent of those in jails and prisons have serious mental illness. He noted that one out of seven people with bipolar disorder end their own lives. This is fifteen times the national average.

Mr. Stanley added that there are also the people whose lives are harmed because the symptoms of another go untreated. He said this is somewhat of a taboo subject in the mental health field. Part of that reason is because the public perception of the level of violence attached to people who are symptomatic is grossly exaggerated and many people feel to have any discussion of it adds to the stigma. He said that he and the Treatment Advocacy Center take a different view. That view is that until the violence problem is addressed, there will be no way to solve it in a manner that eliminates the headlines that drive the public impression.

Mr. Stanley said on the other side there is a view that people with mental illness are no more violent than anyone else. In his opinion, this is true, in many cases, as long as they are in treatment but said that most studies done do not reflect this.

Mr. Stanley said what is important is not the overall prevalence of violence amongst people with mental illness, it is the fact that it is a very much greater heightened propensity for violence among a very small subset of people with mental illness. The three factors most often pointed out are substance abuse, a history of violence and not being in treatment.

Mr. Stanley continued that, during the deinstitutionalization era, people were taken out of the hospitals and given civil liberties that could not be overcome even when a person was incapable of rational decisions. This unintentionally created the right to be and remain psychotic. He said above all our society protects the right of people to choose what is best for them but mental illness attacks

the mind. In his opinion the right to choose becomes somewhat hollow when a person is incapable of making a rational choice.

Mr. Stanley stated that almost as quickly as the last state was switching over to an imminent danger standard, states started to reform their commitment laws again. Progress has been made in the following manner:

- Widening the commitment standard. He said that Idaho is on the curve of going forward with reforms.

Mr. Stanley reviewed Idaho standards. For inpatient commitment the person must be likely to injure themselves or others or is gravely disabled. He stated that the Model Law has corresponding standards but they are broader. The Model Law does not limit what can be used as evidence that a person is likely to injure himself or others.

Mr. Stanley said he would recommend that Idaho's commitment law use the Model Law definition of chronic mental illness:

- *Chronically disabled*: may be shown by establishing that the person is incapable of making an informed medical decision and, based on the person's psychiatric history, the person is unlikely to comply with treatment and, as a consequence, the person's current condition is likely to deteriorate until his or her psychiatric disorder significantly impairs the person's judgment, reason, behavior or capacity to recognize reality and has a substantial probability of causing him or her to suffer or continue to suffer severe psychiatric, emotional or physical harm.

This is based on the Montana Code. He said that Idaho's outpatient commitment code is not that different from this and that this is when this definition should probably be used. **Mr. Stanley** said that the Model Law applies this to both inpatient and outpatient care. He noted that this is good for outpatient commitment because the emergency is not dire at this point. It does not require a person to be transported to an evaluation facility. This is not looked at as an immediate emergency or danger situation and the petition process can be followed. At the end of the process, the court can decide.

Mr. Stanley recommended that Idaho expand the emergency evaluation criteria so it is not as contingent on immediate danger and consider adoption of the chronically disabled standard. He also recommended integration of outpatient commitment into a judge's decision. He explained that under Idaho law, inpatient commitment and outpatient commitment are two separate processes. If a person does not meet inpatient commitment criteria, a judge has to release them, but if outpatient commitment exists as an option and the person meets that criteria, a judge could require that in a single hearing.

Senator Stegner asked whether the use of mental health courts was parallel to or the same thing as outpatient commitment. **Mr. Stanley** said the mental health courts are used on the criminal side as

outpatient commitment is used on the civil side. On the criminal side if a person does not follow through with treatment, they go back to jail. On the civil side with outpatient commitment if treatment orders are not followed, the person will be placed in involuntary treatment.

Mr. Stanley said that a study done by North Carolina shows that assisted outpatient treatment for more than six months combined with routine outpatient services (3 or more outpatient visits per month) reduces hospital admissions by 57% and the length of stays by 20 days. He noted that a 20 day reduction is also a significant cost-savings and that this could pay for a full year intensive outpatient treatment program. Outpatient commitment has also reduced arrests; the rearrest rate of those in outpatient was 12% versus 47% of those not in a program within a one year period. In six months of treatment, incidents of violence were reduced by one-half. This also reduced the incidence of victimization of the mentally ill becoming victims of crimes dramatically.

Mr. Stanley reiterated that the outpatient commitment law is a statute that needs to be used. It is already part of Idaho Code, it just needs to be utilized. He noted that many studies regarding the use of outpatient commitment did not find any adverse effects from its use.

Mr. Stanley went on to discuss Kendra's Law. This is New York's law for assisted outpatient treatment. **Mr. Stanley** said that when Kendra's Law was passed there was nothing special from a strict legal function of commitment law perspective. Its standard was not overly broad and the concept of outpatient commitment had been around for 20 years. One thing it did do was to create an infrastructure for the use of outpatient commitment.

This law established that each county mental health department had to designate an outpatient treatment person. People call this person requesting assistance; the county is required to do an investigation to see if the person meets the criteria. If they are determined to need outpatient treatment, the county must file an outpatient petition.

Mr. Stanley continued that New York also has state level people who have oversight over outpatient commitment. These people educate county employees and provide information. These people also troubleshoot.

Mr. Stanley explained that an equivalent use of outpatient commitment in Idaho, as New York uses Kendra's Law, would be about 100 people under orders in the state at any given time. He noted that this is not a huge number in terms of taxing resources of the mental health system relatively speaking. He pointed out that these laws are not for all people with mental illness.

Kendra's Law reduces the severest consequences from lack of treatment. **Mr. Stanley** said that during the course of court-ordered treatment, when compared to the three years prior to participation in the program, assisted outpatient treatment recipients experienced far less hospitalization, homelessness, arrest and incarceration. In his opinion this works because it puts people in contact with the system periodically so if they start to deteriorate, it can be detected at an earlier stage.

Mr. Stanley said that researchers with the New York State Psychiatric Institute and Columbia University conducted face-to-face interviews with assisted outpatient treatment recipients to assess their opinions about the program. Although about one-half were angry or embarrassed to have been ordered into treatment, after their treatment, recipients overwhelmingly endorsed the effect of the program on their lives.

Mr. Stanley distributed a handout that includes more information and data regarding how Kendra's Law works and percentages associated with its effectiveness. This is available from the Legislative Services Office.

Representative Henbest said that in looking at Idaho's outpatient commitment hearing it seems to be a permissive process that "can be engaged in." Her understanding of the New York law is that it is mandatory "if a person meets the criteria, the county **must** file a petition for outpatient hearing." **Mr. Stanley** said that was correct but that there is still discretion amongst counties as to how much this is used.

Senator Stegner said it seemed to him that the Model Law uses the same standard for inpatient and outpatient commitments and allows for a single hearing for placement in either one. In his opinion this gives the judge the option to order outpatient commitment if the person does not meet the standard for inpatient commitment. **Mr. Stanley** said that was correct and that is what he was suggesting for Idaho.

Senator Stegner asked **Judge Ford** if that would be helpful and **Judge Ford** responded that in his opinion the tools are in place to do this today. He said the prosecution could ask for this during a hearing. He noted that it may be a training issue for the prosecuting attorney and that perhaps they should make themselves available to families who want to do outpatient commitment. The petition could contain outpatient commitment as a second option.

Tracey Sessions commented that, in her opinion, Idaho Health and Welfare employees and the courts thought the outpatient law would eliminate the need to go back to court to get an inpatient commitment. She said everyone needs to realize this is about a different type of treatment and it is not about streamlining the system or making it easier for the courts or the employees.

Holly Koole, Ada County Prosecutors Office commented that they use a system called Thirty Day Abeyance. If someone is found not to be in need of commitment, the person is given certain requirements to meet in order to avoid commitment. She said the attorney signs, the judge signs and the patient/family members sign an agreement to follow these requirements. **Judge Ford** said he believes there is a ten day type of abeyance in the Model Law. He asked if there have ever been concerns that a patient who has been released would commit a serious crime against someone else or themselves. **Ms. Koole** said that could be an issue. **Linda Hatzenbuehler** a Designated Examiner from Pocatello, said that the judges in her area use the same type of abeyance but the person has to meet inpatient criteria to get this.

Gary Payne, psychologist, commented that something about the Idaho law is lacking since it has not been used. He suggested that modifying the law to clarify responsibilities might make it more useable. He also suggested clarifying how to get someone into treatment if they begin to deteriorate as an outpatient.

Representative LeFavour commented that in some areas of the state a person committed to outpatient treatment might have very limited options for treatment. She said this difference in regions and resources might need to be addressed before this could work statewide. She asked if being established as "gravely disabled" allows someone instant access to Medicaid benefits that would allow for that treatment. **Ms. Sessions** said there is not automatic access to the Medicaid system. She noted that the challenge becomes indigent care in Idaho.

Mr. Stanley concluded with two suggestions for Idaho's commitment law. The first was that the detention procedure for emergency evaluation seems cumbersome (police do the pickup; within 24 hours goes to court; 24 hours goes to examiner; 24 hours goes to the prosecutor). In most states the police bring the person to the emergency psych facility and the examiner looks at them. If the person does not meet criteria, they have to be released but if they do meet the criteria, the time frame is the same as in Idaho. **Judge Ford** said in reality this is done more quickly in Idaho than required in statute. He has usually received the exam from the designated examiner by the time it gets to court.

Mr. Stanley went on to say that section 66-327, Idaho Code, seems to put the burden of payment on the patient, spouse or even adult child. **Judge Ford** said that is not used that much in the context of mental health commitment but he has seen it used in the case of Medicaid services more often.

Mr. Stanley noted that according to statute the hospital is required to initiate termination if a person no longer meets the criteria for commitment. Some states have discharge when appropriate. He suggested allowing the person to initiate the release process but not to put so much responsibility on the doctors.

Mr. Stanley said he was surprised to hear that conditional release is frequently used and asked if there is trouble with coordination between the hospital and outpatient services. **Ms. Sessions** said that once someone is conditionally released, in order to get recommitted, they have to go through the entire court process again. **Mr. Stanley** noted that most states rarely use conditional release because the onus is on the hospital to manage the outpatient care.

Mr. Stanley said that the guardianship statute sounded like something that should be better utilized. He noted that as the statute is set up, it is not a long-term solution to extended care. **Judge Ford** said the alternative is to file for regular guardianship.

Mr. Stanley explained that South Dakota and Nebraska have a psychiatric treatment board as the decision-maker in these proceedings rather than a single judge. This board is appointed by the district court and is a standing board. He said they normally are compensated for their work and consist of a lawyer, a mental health professional and one other person.

Candice Crow, psychologist, asked whether New York addresses commitment for substance abuse as well as mental health. **Mr. Stanley** said if they do, it is not in the mental health statute.

In response to a question from **Ms. Sessions, Mr. Stanley** answered that New York uses law enforcement for inpatient transportation because of the immediate danger to self or others standard. He said he is not sure what they do for Kendra's Law pickups. He added that Vermont has a new law that requires that a person be transported by medical personnel unless they are determined to be an immediate danger to self or others.

Dr. Mary Perrien, Chief, Division of Education and Treatment, Department of Correction was the next speaker. Her presentation focused on inpatient care and involuntary commitment and a discussion of the secure mental health hospital design. A copy of her complete PowerPoint presentation is available from the Legislative Services Office.

Dr. Perrien commented that prevention is a very important part of the issue in her opinion and it is often left out of the equation. She explained that involuntary inpatient commitments consist of persons who have been found to be:

- A danger to themselves or others or gravely disabled
- Forensic (Section 18-212, Idaho Code) - these are individuals who have been found incompetent to stand trial
- Criminal

She noted that within the criminal portion, some of these people realize that they have mental illness and accept treatment and others do not. In these cases they have to be handled as an involuntary commitment with the same court process.

Dr. Perrien said that generally involuntary inpatient commitments go to a state hospital unless they are considered dangerously mentally ill. If they are found to be dangerously mentally ill, the federal statute allows that they be committed to the Department of Correction. This is now referred to as the Idaho Secure Medical Program Unit (Section 66-1301, Idaho Code).

She explained that Section 66-1301, Idaho Code, was revised this session to change the term "Facility" to "Program." Currently these patients are housed in one housing unit at the maximum security institution. There are twelve beds for the most acute mentally ill and civil commitments. She noted that this is heavy on security and somewhat lacking on treatment. These twelve beds are to provide care for the entire inmate population as well as those individuals who are considered dangerously mentally ill.

In response to a question from **Representative Henbest, Dr. Perrien** explained that these are people that cannot assist in their defense but are deemed too dangerous to go to a state hospital. She added that the statute allows for people to be housed with the Department of Correction who have no pending criminal charges that are just experiencing mental illness and may be violent or dangerous. She said currently they have an individual that has no pending charges at this time but would be charged with murder if ever restored to competency.

Dr. Perrien defined the term "forensic" as implying that there is some legal aspect to it or criminal charge pending. She said the population they get that are forensic are people that have criminal justice cases or criminal charges pending.

Dr. Perrien's presentation included slides comparing the environment at the Idaho Maximum Security Institution (IMSI) and Idaho State Hospital South. Her point was that the environment at IMSI is not very conducive to treatment.

Dr. Perrien explained that options for treatment for convicted felons include:

- Idaho Secure Medical Program Unit (C Block and IMSI)
- Behavioral Health Unit (once activated this will provide 118 intermediate level and 118 of the lowest level of care beds and sheltered living)

She thanked the Legislature for changes that were made to the statute during the last session and said it allowed them to get the people out of their cells.

Senator Stegner asked when the Behavior Health Unit would be activated. **Dr. Perrien** said they have set an activation date of December 15, 2007.

Dr. Perrien went on to discuss the scope of the Department's needs. She explained that the Department has implemented a new classification system for individuals within the prison system who are experiencing mental illness. This is similar to what Health and Welfare has and includes:

- Qualifying diagnosis - based on constitutional mandates and knowledge in the field and community standards of care
- Individual is categorized by their functional level (within the prison system)
- Individual case is prioritized - this allows increased services for increased needs

Dr. Perrien said in a way this could revolutionize the Department because in the past services have been delivered in a somewhat haphazard manner due to the lack of classification.

Dr. Perrien said at this point about one-third of all inmates have been identified as having some form of mental health need. It is estimated that 20-25% of male inmates and 50-70% of female inmates have a qualifying diagnosis. She said there are increasing numbers of severely mentally ill entering the Department of Correction.

Dr. Perrien noted the challenges in the existing system are:

- Insufficient bed space for existing Department mental health population
- No inpatient beds in the Correction Department so they must rely on state hospitals
- Health and Welfare needs an estimated 40-50 beds annually
- The criminalization of the mentally ill

Representative Henbest asked whether those 40-50 beds are secure beds. **Dr. Perrien** said that was correct.

She explained that the solution lies with the Idaho Secure Mental Health Hospital. She noted that this is a compromise solution. Ideally, convicted felons would be housed in one location and people

not convicted of a crime in another very different facility. This solution allows the Department to comply with the original intent of the statute that included the spirit of having a place for these individuals to go to receive treatment in a humane environment that is also secure. The Idaho Secure Mental Health Hospital would:

- Be a secure mental health facility
- Comply with the spirit of section, 66-1301, Idaho Code
- Serve a population including:
    - sentenced mentally ill
    - pre-adjudicated dangerously mentally ill (section 18-212, Idaho Code)
    - dangerously mentally ill civil commitments
    - male and female

Kathleen Allyn, Administrator, Division of Behavior Health, Health and Welfare Department, continued the presentation. She reiterated that adults who can be committed involuntarily to the custody of the Department of Health and Welfare include:

- People found by the courts to be a danger to others because of mental illness, and
- People who are incapable of assisting in their own defense in a criminal trial

She stated that individuals in these categories can be dangerous and may have created violent acts. The law provides a mechanism for transferring custody of the dangerous to the Department of Correction. She noted, however, that the twelve bed psychiatric unit that the Department of Correction has is almost always full and Correction is unable to take the clients.

Ms. Allyn continued that the Department of Health and Welfare has no secure facility to take care of dangerous clients. In the course of a year, there are about 40 adults who need to be kept in a secure environment to prevent harm to others. About 30 of those have committed violent acts but cannot stand trial because they cannot assist in their defense and about 10 of them have not engaged in criminal behavior but need to be kept in a secure facility to prevent them from harming others.

Ms. Allyn said that the facility being developed by the Department of Correction will address the problem but it is not expected to be in operation for at least three years. In the meantime, there is a need for an interim secure psychiatric facility to house the 20 or so dangerous clients in Health and Welfare's custody on any given day. State staff are currently being asked to take care of dangerous people in facilities and settings that were not designed for that purpose. She said this not only puts staff at risk, but it poses a risk of injury to the client, other clients and the public, in the event of an escape from a nonsecure building.

Ms. Allyn stated that Health and Welfare has met with the Department of Correction to coordinate efforts to design a system of care, not a patchwork of services. They are looking to modify an existing building at the Idaho State School and Hospital (ISSH) to serve as a 20 bed secure facility.

She noted that there are several buildings at the ISSH that have floor plans that appear to lend themselves to being modified to make them secure facilities. The Division of Behavioral Health has

contracted with the mental health program of the Western Interstate Commission for Higher Education (WICHE) to look at these buildings and assess the feasibility and cost of making one a secure psychiatric facility. **Ms. Allyn** said they are anticipating the results of this review prior to the next legislative session.

The current ISSH residents would be relocated to smaller, less institutionalized settings that would allow adequate supervision with a more homelike atmosphere. She said this type of housing has been shown to result in improved care and better outcomes for people with developmental disabilities.

Ms. Allyn said that once the Department of Correction facility is up and running a reevaluation of the need for the interim psychiatric facility versus other uses would be done. Options include:

- Converting the facility to a short-term crisis stabilization facility which can reduce the need for hospitalization;
- Converting the facility to a transitional facility to assist patients to successfully return to the community after hospitalization;
- Converting the facility to a psychiatric hospital serving southwest Idaho; or
- Some combination of all of these options.

Representative Henbest asked whether this interim step could happen with ISSH clients on the campus or would they be relocated. **Ms. Allyn** said that the plan at this time is to co-locate. She said that is why they are bringing in the consultant to make sure this would be possible. She noted that there would have to be separation of some kind.

Senator Stegner commented that ISSH is a very specialized facility that is fairly large and offers a site for additional development for the state with limited land acquisition costs. He said he has felt for some time that the focus of that institution needs to be reevaluated. It is not a state hospital; those are in Blackfoot and Orofino and they deal with mental commitments. The ISSH does not do this. He said he was aware of this concept and feels that it deserves this committee's consideration. He suggested having their next meeting there with another tour.

In response to a question from **Senator Lodge**, it was stated that there are about 500 to 700 acres on the ISSH campus that are not part of the golf courses. **Senator Stegner** suggested there is more than ample expansion space available without disrupting existing leaseholders.

Dr. Perrien continued the presentation. She explained that the Idaho Secure Mental Health Facility plan is a joint venture with Health and Welfare. She outlined the facility and program in the following five phases.

- Phase 1: physical plan design with joint mission focus
    - who will have administrative oversight
    - who will manage day to day operations
    - pay equity
- Phase 1A: Request facility in capital budget

- Phase 2: staffing analysis
  - would not require 300 inpatient beds
  - staff would vary by acuity
- Phase 3: Recruiting and Hiring
  - Remodel/Build out
- Phase 4: Establishing policies and standards
- Phase 5: Activation

Dr. Perrien explained that money was allocated during the last legislative session to address planning and design. A group has been identified to participate in planning meetings. Initial sites have been identified for review and a schedule is being developed for site visits.

She went on to give examples of companies they are looking at to use for design of this facility. One company they are looking at is KMD. They are a large well-known architectural design firm which has designed multiple health care and state hospital facilities and prisons. **Dr. Perrien** said that KMD recognizes that the environment is very important and that a person can recover more quickly if the environment is designed correctly. They are very focused on trying to eliminate the institutional feel of a facility.

The KMD philosophy reflects:
- a positive relationship exists between the quality of the physical environment and the well-being of the confined patient
- facilities where patients would be able to take responsibility for their own well-being in a place of warmth and calm

Her presentation also includes KMD's rendering of what the Idaho facility might look like.

Dr. Perrien closed by saying that there is clearly a need in Idaho that is only going to get bigger. She said if this facility is done properly, it is her belief that there can be one facility that meets everyone's needs and does not further stigmatize people who are experiencing mental illness. It can be a safe and secure facility. She said one other advantage this facility could provide in the future would be to allow co-occurring treatment for substance abuse and mental health treatment.

Senator Stegner asked what the current appropriation is going to be used for. He confirmed that no additional money is being spent for design at this point. **Dr. Perrien** said that is open to clarification. It is their understanding that it is to be used to look at ensuring that there is a need for such a facility, to look at facilities and identify one that would match Idaho's needs and make that recommendation in the capital budget request. **Representative Henbest** commented that $3 million is a generous appropriation and thinks there should be some left over after this planning. **Dr. Perrien** agreed. **Senator Stegner** clarified that the initial emphasis would be an evaluation of existing facilities. **Dr. Perrien** said yes, to see if there is an existing facility available that would meet their needs, or an existing site. She said she did not believe this will take an entire year and the Department got the message to do this as soon as possible. She anticipates having the information

on this by the time the next legislative session starts and still have money left over.

Senator Stegner said it was his understanding that of the 300 bed unit that has been asked for, Health and Welfare's 40 to 50 beds for involuntary commitments would be housed in a separate wing. **Dr. Perrien** said that was correct. She said there are many different ways to get that separation to minimize the criminal element. She added that having expansion capacity built in to the design is very important.

Senator Stegner asked in reviewing existing buildings whether they are looking at state buildings that are not currently being used and if so that would mean that the facility is the primary focus with the location being secondary. **Dr. Perrien** said not necessarily because it has to be placed where it can be staffed.

Senator Stegner commented that one advantage of this type of facility for the state at this time is the shared resources and economy of scale in terms of staffing and services. In response to another question from **Senator Stegner, Dr. Perrien and Ms. Allyn** agreed that the Department of Correction and Health and Welfare are working very closely in order to reach this goal. **Ms. Allyn** added that discussions to include an expanded capacity for a state hospital in the Treasure Valley are part of the picture. **Amy Castro, Legislative Services Budget and Policy Office** commented that on June 28, the Department of Correction, Health and Welfare and the Legislative Services Office met to discuss this.

Senator Lodge said she was very excited to see this collaboration and commended both departments for working on this large problem.

Representative Henbest asked if there were any KMD projects in Idaho. **Dr. Perrien** said no, they were partnering with a firm in Idaho but do not have any actual projects.

Amy Castro, Legislative Services Budget and Policy Office gave a review of actions taken by the 2006 Interim Committee on Mental Health. Her presentation included a flow chart of how individuals flow through the Health and Welfare system that identified gaps in services. This is available at the Legislative Services Office.

She distributed a handout that was developed using information from the 2006 Interim Committee meetings that identified gaps in services within the system, developed policy questions to help deal with those gaps and explained legislative action that was taken.

State Hospitals and Secure Mental Health Treatment
Gaps in Service

- State hospitals and private providers do not have the capacity to meet the current needs of eligible individuals
- Section 66-1301, Idaho Code, requires a stand alone secure mental health facility but

currently one is not available (This section was amended during the 2007 Legislature by Senate Bill 1213)

- State hospitals do not currently take voluntary commitments, thus someone has to commit a crime or be considered a "danger to themselves or others" before treatment is provided.

Policy Question

"How does Idaho meet the needs for eligible populations that require a secure or nonsecure hospital like treatment environment."

2007 Legislative Actions Taken

- Supporting a secure mental health facility that would house individuals under section 66-1304, Idaho Code.
    - HB 325 provided $3,000,000 in one-time funding for the design and planning of a Secure Mental Health Hospital/Facility.
    - HB 330 set aside $60,000,000 in one-time funding as a reserve account that may be used to fund the initial construction costs of this facility.
    - SCR 108 and funding for the implementation plan are responsible to review state hospital capacity.

She noted that approximately 236 inmates meet the severe and persistent mental illness definition and are currently housed in the state prison system and that a secure mental health facility is estimated to provide 50 beds for the current state hospital system.

Her handout and presentation also covers gaps in service and legislative action that was either taken or proposed for substance abuse, the offender population and overall system issues.

Representative Henbest asked whether an RFP would be used to decide upon the consultant. **Ms. Castro** said an RFP could be used but she does not think it is required. They chose to just interview people and one person interviewed has worked with OPE and is familiar with Idaho's system. She said with the time frame involved it would be difficult if the person chosen is not familiar with Idaho. It will be a very collaborative process and state agencies and individuals will work together to get this completed.

Ms. Castro also distributed a draft of action items for the implementation plan. This is also available in the Legislative Services Office. Action items include:

- Review management structure of Idaho's Mental Health and Substance Abuse Services
- Create improved system access for Mental Health Services for adults
- Create improved system access for Mental Health Services for children
- Create a timeline and plan for implementation of all systematic changes

Senator Stegner encouraged members to review the draft implementation plan and submit comments to **Ms. Castro** as soon as possible. In order to get the ball rolling he suggested doing an in-house prioritization.

Representative Henbest noted that they seem to have keyed in on a core work group that will advise and control how this will progress and in her opinion using someone familiar with Idaho will help move this along more quickly.

Senator Stegner asked for members to suggest additional meeting topics for future meetings. **Representative Henbest** said she would be interested in further presentations or discussion of the intervention bill that was passed last session but not funded. **Senator Stegner** said that the Division of Behavioral Health has made it a priority for the state to recognize co-occurring disorders as a priority and to start recognizing the need for both mental health and substance abuse treatment. **Ms. Castro** commented that what treatment should look like is the core issue of the implementation plan along with commitment laws and facilities.

Senator Stegner suggested adding discussion of team intervention to the agenda. **Senator Corder** agreed and said he would like to make funding this a priority. **Representative Henbest** also suggested having a presentation by Idaho Voices for Children.

Senator Corder voiced concerned about interaction in private facilities between juveniles and adults and said he would like more information.

The next meeting of the subcommittee will include a tour of the Idaho State School and Hospital in the morning. The meeting was scheduled for August 27.

The meeting was adjourned at 4:15 p.m.